DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/23/16

PRINTED: 06/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445156	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTH CARE	902 BUCHANAN RD NEW TAZEWELL, TN 37825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 1-story Type V(111), protected, combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: 1983 K7 SURVEY UNDER: 2000 EXISTING K8 134-bed SNF/NF	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were provided with a means suitable for keeping the door closed. (NFPA 101-2000 Edition, 19.2.2.2.1, 19-3.6.3.) The findings include: 1. Observation and interview with the	K 018	1) The latch on all 3 doors were replaced with new latches and the door closer for door #3 was also replaced on June 6. 2) All doors in the center were inspected to ensure that they closed and latched properly. This was completed by June 24. 3) A monthly inspection of all doors will be accomplished for a period of 6 months. Thereafter quarterly inspections of all doors will occur. 4) A report will be made by the maintenance director at the monthly QAPI committee meeting for 6 months and then quarterly thereafter.	6/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert S Pelham	Admn	7/1/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 Maintenance Director, on 6/6/2016 at 1:27 PM confirmed the lighthouse dayroom corridor door failed to close to a positive latch. 2. Observation and Interview with the Maintenance Director, on 6/6/2016 at 1:28 PM confirmed the room 114 door failed to close to a positive latch. 3. Observation and Interview with the Maintenance Director, on 6/6/2016 at 1:27 PM confirmed the office door across from dietary failed to close to a positive latch. These findings were verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on 6/6/2016.	K 018		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure hazardous area ' s construction is maintained. (NFPA 101, 19.3.2.1 (7). The findings include: Observation and interview with the Maintenance Director, on 6/6/2016 at 1:33 PM confirmed doors were not self-closing in the following hazardous areas: a) 100 hall biohazard room	K 029	1) Door closers were replaced on all 3 doors that were identified by June 24. 2) The Director of Maintenance inspected door closers for all hazardous areas. This was completed by June 24. All doors closed and latched. 3) A monthly inspection of all doors will be accomplished for a period of 6 months. Thereafter quarterly inspections of all doors will occur. 4) A report will be made by the Maintenance Director at the monthly QAPI committee meeting for 6 months and then quarterly thereafter.	6/30/16

Robert G Palahan

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K 029	Continued From page 2 b) Business manager's office c) MDS office This finding was verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on 6/6/2016.	K 029	K 038 1) One of the locking mechanisms was eliminated on the office door for the Director of Nursing Services on June 30.	6/30/16
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors in the means of egress did not have more than one releasing motion. (NFPA 101-2000 Edition, 7.2.1.5.4) The findings include: Observation and interview with the Maintenance Director, on 6/6/2016 at 11:28 AM confirmed the door to the DON's office had 2 releasing motions to exit (deadbolt and doorknob). This finding was verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on 6/6/2016.	K 038	2) An inspection was made of the center to determine if there were any other doors with similar dual locks. One other door locking mechanism was identified and was removed on June 30. 3) A monthly inspection of all doors will be accomplished for a period of 6 months. Thereafter quarterly inspections of all doors will occur. 4) A report will be made by the Maintenance Director at the monthly QAPI committee meeting for 6 months and then quarterly thereafter.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire one (1) hour fire rated construction is maintained. (NFPA 101, 8.3.5.1) The findings include: 1. Observation and interview with the Maintenance Director, on 6/6/2016 at 11:11 AM confirmed the therapy room has two unsealed penetrations in the ceiling where PVC conduit penetrate above the electric panel.	K 130	K130 1) The 2 unsealed penetrations above the ceiling in therapy were sealed with an approved fire caulk on June 6. The fire damper was reinstalled on June 6 into the 12" x 12" opening in the ceiling of the employee break room. 2) The Maintenance Department inspected all areas above the ceiling and the ceiling itself for penetrations and openings during the week of June 13. There were no other penetrations or openings found.	6/30/16

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K 130	Continued From page 3 2. Observation and interview with the Maintenance Director, on 6/6/2016 at 11:20 AM confirmed the employee break room ceiling had a 12" x 12" opening in the ceiling. These findings were verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on 6/6/2016.	K 130	K130 (continued) 3) A quarterly inspection of all areas above the ceiling and the ceiling itself will be accomplished. An inspection will also be made immediately after any work done above the ceiling by outside contractors. 4) A report will be made by the Maintenance Director at the quarterly QAPI and Safety committee meetings.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a sufficient number of receptacles so as to avoid the need for multiple outlet adapters. (NFPA 99, 3-3.2.1.2 (d) (2). The findings include: Observation and interview with the Maintenance Director, on 6/6/2016 at 9:200 AM confirmed the use of two multiple plug adapters in the conference room. NFPA 101-2000 Edition, Sections 19.5.1, 9.1.2, NFPA 99 7-5.1.2.4, 9-2.1.22, NFPA 70 Article 400-8, S&C 14-46 This finding was verified by the Maintenance Director and acknowledged by the Administrator during the exit conference on 6/6/2016.	K 147	K147 1) The director of maintenance on June 6 removed the 2 multi-plug adapters that were identified during the survey. 2) The Director of Maintenance performed an inspection of all outlets in the center which was completed by June 30. 2 additional multi-plug adapters were found and removed. 3) A quarterly inspection of all outlets in the center will occur. 4) A report will be made by the Maintenance Director at the quarterly QAPI and Safety committee meetings.	6/30/16

Robert B Bolcher